

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/23/2015
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was a State hospital complaint investigation.</p> <p>Complaint: #IN00151466 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 011437</p> <p>Survey Date: 01/23/2015</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Community Hospital North is in compliance with 410 IAC 15-1.5-5, Medical Staff, and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: cloughlin 02/23/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE